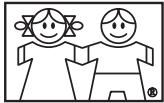


# SCREENING RECORD

# CHMPC

Children's Hospital Medical Practice Corporation



Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Chart No. \_\_\_\_\_

## 15 Month

Date \_\_\_\_\_ Time \_\_\_\_\_  
Actual Age \_\_\_\_\_ Weight \_\_\_\_\_ lb \_\_\_\_\_ oz. Height \_\_\_\_\_ in.  
Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_ Head Circ \_\_\_\_\_ Pain Score (0 – 5) \_\_\_\_\_  
☐ Environmental Screen ☐ Lead Risk Assessment ☐ Growth chart plotted ☐ PDQ done at 12 mos.  
Nutrition: ☐ Breast ☐ Whole Milk ☐ Solids ☐ Vitamins ☐ Fluoride  
Adverse Reactions (drug allergies): ☐ Yes\* \_\_\_\_\_ ☐ No \*If yes, also list on Patient Problem Summary in front of chart.  
☐ Parent section reviewed? ☐ Parent's concerns addressed  
☐ Immunizations current (copy in chart) ☐ Off Schedule ☐ Parental Refusal Explain \_\_\_\_\_  
Problems: \_\_\_\_\_

**Current Medications:** ☐ None or list medications below.

Name	Dose	Frequency

Nurse's Signature

X

**Physical:** Check (☑) if normal. Circle if abnormal and describe.

☐ General Appearance

☐ Head/Face/Neck

☐ Eyes

☐ ENMT

☐ Respiratory

☐ Chest

☐ CV

☐ Abdomen

☐ Genitalia

☐ Skin

☐ Lymph nodes

☐ Extremities ☐ Hips

☐ Musculoskeletal

☐ Back

☐ Neuro

**Anticipatory Guidance:** ☐ Home Safety ☐ Car Safety ☐ Immunization Information  
☐ Nutrition ☐ Medication Education (if applicable)

**Assessment:** \_\_\_\_\_  
\_\_\_\_\_

**Plan:** ☐ DTaP ☐ Flu ☐ Hgb or CBC (If necessary \_\_\_\_\_ value) ☐ Counseled  
☐ Hearing Subjective: Pass \_\_\_\_\_ Fail \_\_\_\_\_ ☐ Vision Subjective: Pass \_\_\_\_\_ Fail \_\_\_\_\_  
☐ Other: \_\_\_\_\_

☐ Interpretive Conference Conducted Return \_\_\_\_\_  
☐ Parent/guardian instructed to keep **Current Medication List** to share with other providers and for emergencies. **INITIALS** \_\_\_\_\_  
☐ Parent/guardian verbalized understanding the **Plan of Care**. **INITIALS** \_\_\_\_\_

Physician/Practitioner's Signature

X

Date

/ /

Time

AM/PM

:

## Parent Section 15 Month

### SECTION TO BE COMPLETED BY PARENT

#### Personal/Social History

##### *Does your child...*

(check appropriate box for each question)

- |                                                   | Yes                      | No                       |
|---------------------------------------------------|--------------------------|--------------------------|
| 1. Say 3 – 6 words clearly?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Understand simple commands or request?         | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Indicate wants by pulling, pointing, grunting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Show fear, anger, affection, jealousy?         | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Feed self with fingers?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Drink from a cup?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Walk well, stoop and climb stairs?             | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Stack two or more blocks?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ride in a safety seat in the rear?             | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Live in a gun-free home?                      | <input type="checkbox"/> | <input type="checkbox"/> |

##### *Are you **CONCERNED** about your child's...*

- |                                                  |                          |                          |
|--------------------------------------------------|--------------------------|--------------------------|
| 11. Feedings?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Is he/she still taking the breast or bottle? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Bowel movements?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Sleep habits?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Excessive whining?                           | <input type="checkbox"/> | <input type="checkbox"/> |

16. Is your child attending day care? ☐ Yes ☐ No

#### Parent Section

☐ Mother ☐ Father ☐ Other \_\_\_\_\_

17. Do you have smoke alarms in your house? ☐ Yes ☐ No

#### Environmental Screening

##### *Does your child...*

- |                                                                                                                                      | Yes                      | No                       |
|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 18. Live in or regularly visit a house built before 1950 (daycare, baby sitter or relative)                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Live in or regularly visit a house built before 1978 with recent or ongoing renovation or remodeling (within the past 6 months)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have a sibling or playmate who now has or did have lead poisoning?                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Does anyone smoke in the household?                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you have a swimming pool?                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |

#### History Update

- |                                                                    | Yes                      | No                       |
|--------------------------------------------------------------------|--------------------------|--------------------------|
| 23. Has there been a change in your child's medical history?       | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Has there been a change in your child's family medical history | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Change in household situation?                                 | <input type="checkbox"/> | <input type="checkbox"/> |

#### Parent Comments (Please Print)

- |                                                   | Yes                      | No                       |
|---------------------------------------------------|--------------------------|--------------------------|
| 26. Do you have any concerns you wish to discuss? | <input type="checkbox"/> | <input type="checkbox"/> |

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Signature

**X**

Date MM/DD/YY

/ /

Time 00:00 AM/PM

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